Access To Publicly Funded Mental Health & Substance Abuse Services In Virginia

Commission on Mental Health Law Reform

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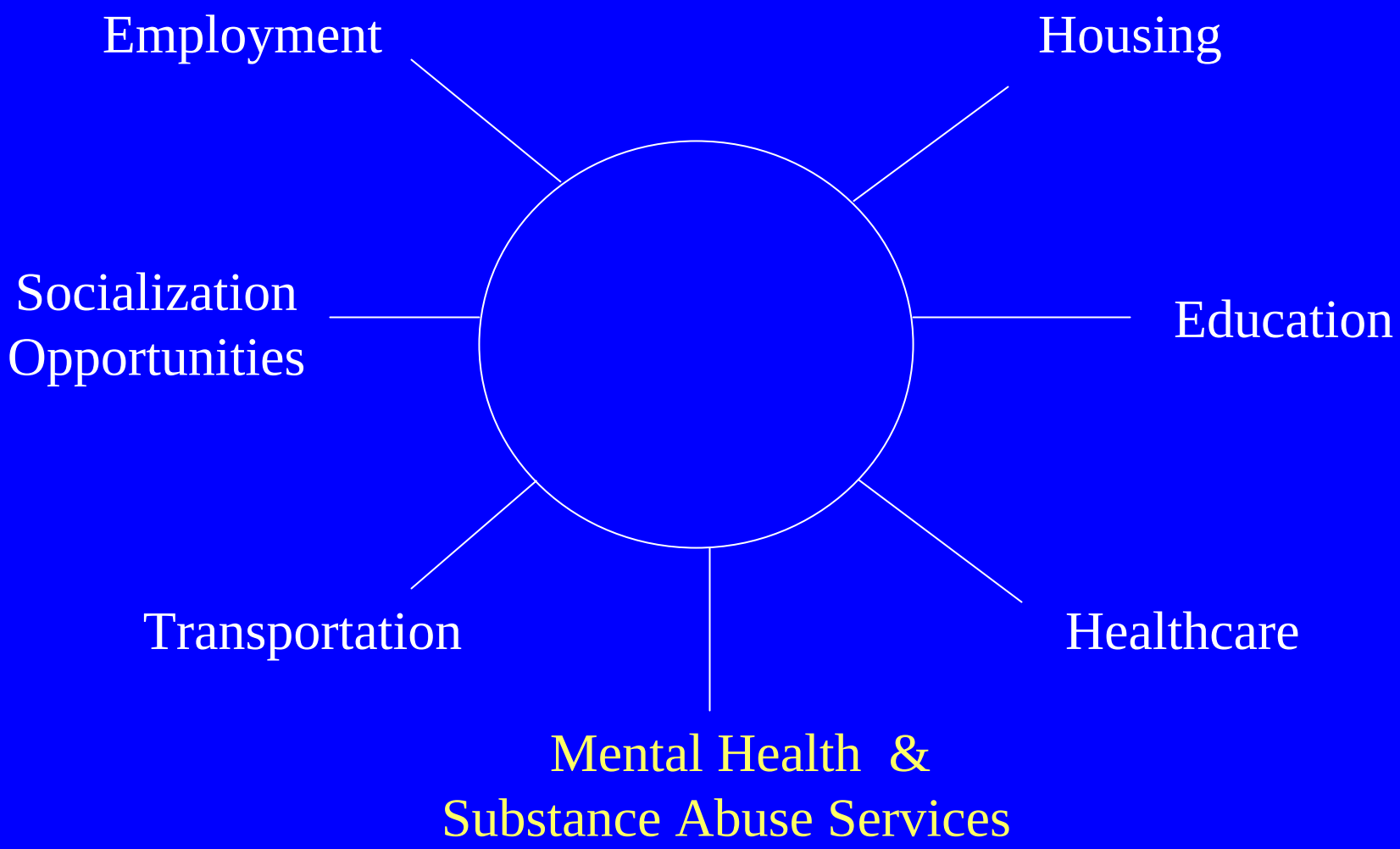
James W. Stewart, III

Inspector General

Needed Life Activities/Supports



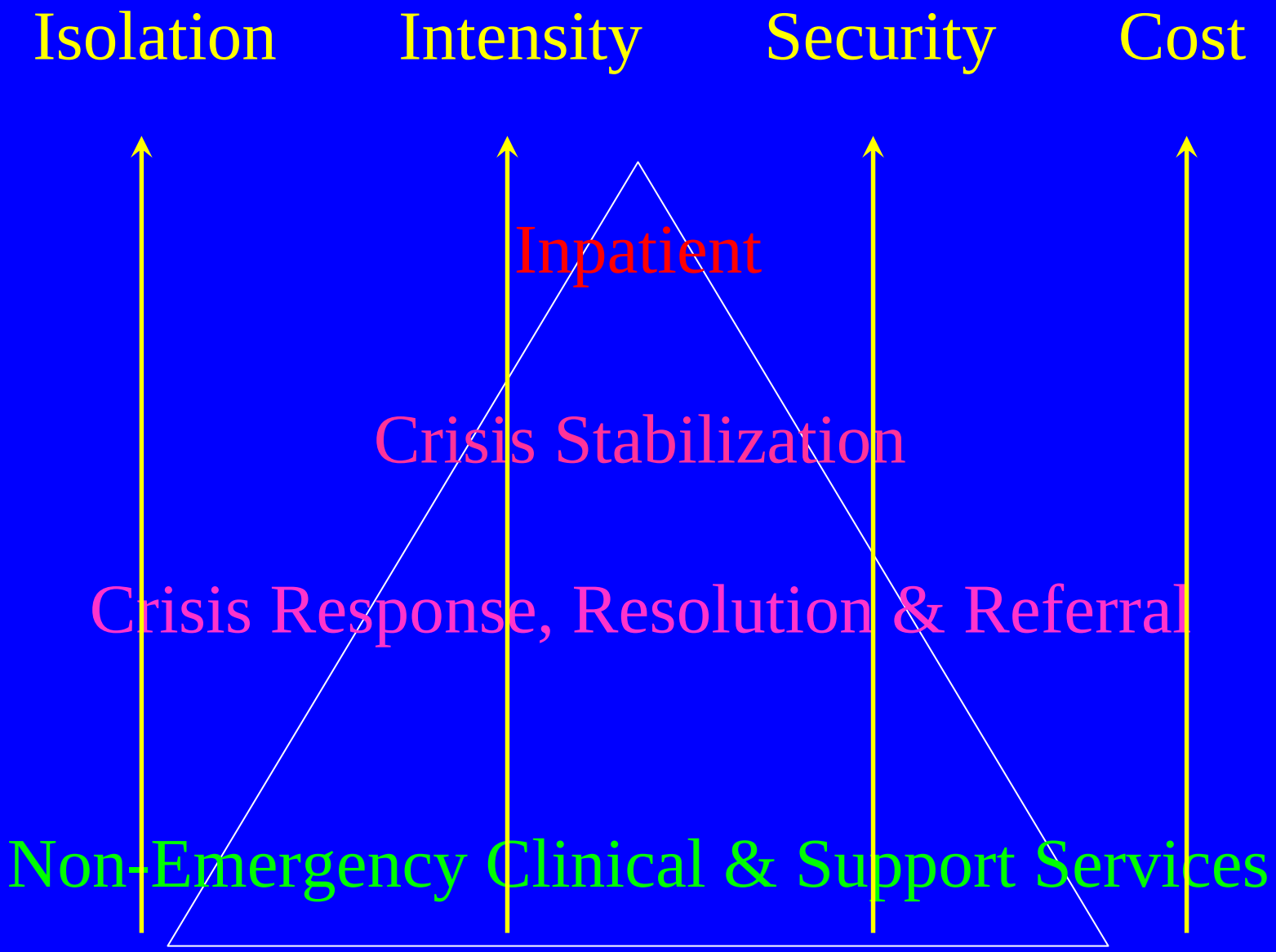
Progression of Mental Health & Substance Abuse Services

Comprehensive Array of Non-Emergency Clinical and Support Services

- Outpatient individual, group, family therapy
- Psychiatric services including chemotherapy
- Program of Assertive Treatment (PACT)
- Psychosocial rehabilitation
- Supported living/in home services
- Residential treatment
- Case management

Comprehensive Array of Crisis Intervention Services

- Inpatient Hospital
  - State hospital
  - Local hospital
- Community Crisis Stabilization Programs
  - Residential Crisis Stabilization
  - In-home Crisis Stabilization
- Crisis Response, Resolution and Referral
  - Mobile crisis outreach teams
  - 24 hour face-to-face crisis counseling
  - 24 hour telephone crisis counseling


Isolation
Intensity
Security
Cost
Inpatient
Crisis Stabilization
Crisis Response, Resolution & Referral
Non-Emergency Clinical & Support Services

Intervention Goals

- Intervene as early as possible
- Provide thorough evaluation/assessment
- Provide all services needed and match intensity to need
- Coordinate to assure timely access to both clinical services and community support

Recent OIG Reviews Focusing On Access To Services

- CSB Emergency Services Programs
- CSB Case Management Services
- Community Substance Abuse Services for Adults
- Combined scope:
  - 83 site visits
  - 1095 interviews with consumers
  - 754 interviews with staff and supervisors

Finding #1

Non-emergency community-based support and clinical services provided in the community do not have adequate capacity. As a result, Emergency Services Programs deal with crisis situations that could have been prevented if the consumer had received more intensive or a different array of services.

Limited Capacity of Non-Emergency Clinical & Support Services

- All CSB emergency services programs reported that the limited capacity of their non-emergency services results in more crisis situations:
  - Psychiatric services and affordable medications
  - Outpatient
  - PACT
  - Case management
  - Peer support providers
  - Housing
  - Support for jobs

MH Case Managers Regarding Lack of Non-emergency Services

Safe affordable housing of choice	79%
Chance to work with others with MI	79%
Access to psychiatrist without delay	63%
Access to affordable mediations	43%
Access to job training and job support	40%
Access to reliable transportation	Unanimous
Dental services	Unanimous

Finding #2

The majority of CSBs do not provide a comprehensive range of crisis intervention services. As a result, many consumers are denied effective treatment in the least restrictive setting and dependence on costly inpatient care is greater

Office of the Inspector General
Study of CSB Emergency Services

Crisis Intervention Services Continuum (Shaded items indicate community services not widely available)	**# of CSBs Offering Service 24/7**
Inpatient Hospital	
State hospital facility – State hospitals operated by DMHMRSAS	40
CSB hospital bed purchase - Contracted acute inpatient services in private hospital, often closer to home community; CSB involvement in admission, discharge, and treatment coordination more accessible.	35
Community Crisis Stabilization Programs	
Residential crisis stabilization (TDO) - Like the service below, but licensed to accept TDOs, with 24 hour nursing on site, M.D. daily and on-call for assessments and interventions. All of the current crisis stabilization programs are considering accepting TDOs.	2
Residential crisis stabilization service (voluntary) - 24 hour, CSB-operated or contracted, group home model, available in emergencies, sufficient staffing ratios to provide intensive supports to persons in crisis. Includes nursing on site and MD consultation/visits. (This model of crisis stabilization is currently used in three communities. The General Assembly funded seven additional programs 2005.)	9**
In-Home residential support service – CSB staff goes to the consumer's home and provide supports during crises, keep consumer safe and occupied. Level of support is matched to consumer need. Consumer-focused, not program-focused	6*
Consumer-run residential support service - "Safe house" program. CSB/consumer partnership agreement – many consumers prefer to be served by other consumers in a crisis.	2
Crisis Response, Resolution, and Referral	
Mobile outreach crisis team - Off site, face-to-face. ES clinicians go out to assess and serve persons in crisis wherever they may be, e.g., at consumer's home, on the streets, etc. Not just to hospitals, jails, etc.	9*
Psychiatric evaluation and medication administration. Face-to-face crisis medication evaluation and treatment. MD sees consumer, prescribes or administers meds, 24 hours a day.	1
Psychiatric crisis consultation – Telephone medication consultation with ES clinician or consumer; refill, change, call in prescription, etc. – routine, available by policy, not occasional exception.	12*
Face-to-face crisis counseling – **immediate, 24 hours** - With CSB ES clinician**,** without ECO or prescreening requirement. Crisis counseling to resolve or reduce crisis, therapeutic, talk as long as required to address consumer needs.	27
Face-to-face crisis counseling – guaranteed next day with CSB ES staff – Crisis intervention and treatment, may follow contract for safety (not an intake or referral for possible outpatient appointment)	27
Crisis consultation with CSB program (e.g., residential) – For current CSB consumer. ES staff contact the program staff who know the consumer and involve them in stabilizing the crisis, arranging for collaborative intervention, adapting program to address current needs, etc.	30
Telephone crisis counseling - extended - With CSB ES clinician. Crisis counseling on the phone, therapeutic intent, an effort to defuse crisis, provide crisis intervention.	39
Telephone crisis contact - brief - With CSB ES clinician. Initial screening, decision about whether to screen face-to-face, information and referral, assurance about medications, contract for CSB appointment	40
Hotline - a service where consumers can call and talk about their problems and be heard, at length if necessary. Staffed with volunteers, including consumers. Supervised and sponsored by CSB.	11

Finding #3

Almost all CSBs provide the least restrictive crisis response, resolution and referral services and most restrictive inpatient services.

Inpatient Hospital
40 CSBs

- State Hospital 40
- CSB Purchase – Local Hospital 35

Crisis Response, Resolution and Referral

40 CSBs

- Telephone Crisis Contact – Brief 40
- Telephone Crisis Counseling - Ext. 39
- Face-to-Face Crisis Counseling 27
- Psychiatric consultation 12
- Mobile Outreach 9

Finding #4

While the majority of CSB's offer the less intensive Crisis Response, Resolution and Referral Services, capacity limitations restrict service effectiveness, especially in rural areas.

Capacity Problems - Crisis Response, Resolution and Referral Services

- Vast majority of CSBs do not have adequate psychiatric coverage for emergency services
- Only 9 CSBs offer routine mobile services to homes or street - more go out on limited basis to jail, hospital, etc.
- Only 8 CSBs have staff in office 24 hrs/day
- 28 CSBs use answering service or 911 after hours

Capacity Problems - Crisis Response, Resolution and Referral Services

- 40% of stakeholders say they have experienced or heard about delays in access
- 68% of consumers say they have “quick” access to crisis services
- 33 CSBs offer toll free crisis access
- Special communication needs generally met

Access by Telephone Crisis Intervention Services

Length of Wait	Day	Night
1 minute or less	14	6
1 to 2 minutes	12	0
2 to 5 minutes	4	8
5 to 15 minutes	4	14
15+ minutes	5	12
No response	1	0

Finding #5

Very few CSBs offer the mid-range community crisis stabilization programs that can effectively respond to difficult crises in the community.

Community Crisis Stabilization Programs

40 CSBs

- Residential Crisis Stabilization (TDO) 2
- Residential Crisis Stabilization (Voluntary) 9
- In-Home Residential Support 6
- Consumer-run Residential Support 2

Only 13 of 40 CSBs have access to 1 or more stabilization options

Community Crisis Stabilization Programs

- Only 3 residential crisis stabilization programs at the time of the review. 2005 GA action added 8 programs
- 65% of staff and 51% of consumers said increased availability of crisis stabilization programs would decrease the need for more inpatient.

Finding #6

Most communities do not have access to appropriate crisis intervention services for consumers with mental retardation. The role of state hospitals and training centers to serve these consumers is not clear. Results:

- Consumers/staff in dangerous situations
- Consumers referred to inappropriate services
- Often TDO'ed to mental health facility

Finding #7

Range, variety & capacity of substance abuse services are not adequate to meet the needs of consumers in the majority of Virginia communities

Office of the Inspector General
Review of Adult Outpatient Substance Abuse Services

Substance Abuse Services Continuum (Shaded area represent services for which 70% or more of CSBs report inadequate or no capacity)	# of CSBs With Service	# with Inadequate Capacity
Detoxification Services		
Medical Detox- withdrawal from drugs in an inpatient, residential or outpatient setting under medical supervision with the use of medications	31	25
Social Detox - withdrawal from drugs in a residential or outpatient setting without the use of medications	21	14
Medically Assisted Outpatient Treatment		
Agonist Treatment - Outpatient treatment of opiate addicts using synthetic opiate such as Methadone	20	12
Partial Agonist - Outpatient treatment of opiate addicts using Buprenorphine	16	13
Medically Assisted Outpatient Treatment- medications that reduce cravings or produce negative symptoms related to use	18	15
Outpatient Treatment- Drug Free		
Day Treatment - Intensive, 5-7 days a week, over 2 hours per day	10	4
Intensive Outpatient - Intensive, 3-4 days a week, 1-2 hours per day	25	14
Group - 1-2 times a week, 1-2 hours a day	40	19
Individual - 1-2 times a week	40	27
Psycho-Educational Group- Such as ASAP Level I	36	13
Family Support Therapy - Support and educational services	33	19
Aftercare and Follow-up - Ongoing, recurring support	34	20
Case Management - Ongoing outreach assistance	38	27
Services to Persons in Criminal Justice System		
Jail or prison based services- Intensive services for incarcerated persons	25	20
Community based treatment - outpatient treatment contracted by P&P at the CSB or Probation Office	35	20
Drug Court - Diversion and treatment for convicted persons	21	13
Residential Services		
Long Term -24 hours, 6-12 months		
Men	10	9
Women	10	10
Women and Children	12	8
Short Term - 24 hours, 1-6 months		
Men	27	19
Women	26	20
Women and Children	16	10
Halfway House- partially supervised and transitional		
Men	19	14
Women	14	11
Women and Children	7	5
Oxford House - Resident supported, unsupervised group living		
Men	19	15
Women	14	10
Women and Children	5	4
Subsidized Individual Apartment Living - may have staff supports or CM	15	11

Lack of Comprehensive Substance Abuse Services

- Detoxification
  - 25% lack medical detox
  - 50% lack social detox
- Medically Assisted Outpatient
  - 50% lack any opiate maintenance treatment
- Outpatient
  - 75% lack day treatment
  - 38% lack intensive outpatient

Lack of Comprehensive Substance Abuse Services

- Jail Based Services
  - 38% lack service
- Residential Services
  - 75% lack long-term
  - 33% lack short-term
  - Over 50% lack halfway house & Oxford House

Finding #8

Access to substance abuse services requires lengthy waiting period

- Average wait of 25.4 days from first phone call until start of active treatment in outpatient programs
- Average wait of 34.2 days for appointment with psychiatrist

Average Response Time From Call to Active Treatment

CSB Consumers	25.2 days
CSB Staff	25.8 days
CSB Supervisors	23.6 days
Probation & Parole	28.8 days
Overall Average	25.4 days

Finding #9

The mental health needs of persons receiving CSB substance abuse outpatient treatment for adults appear to be under assessed and under treated.

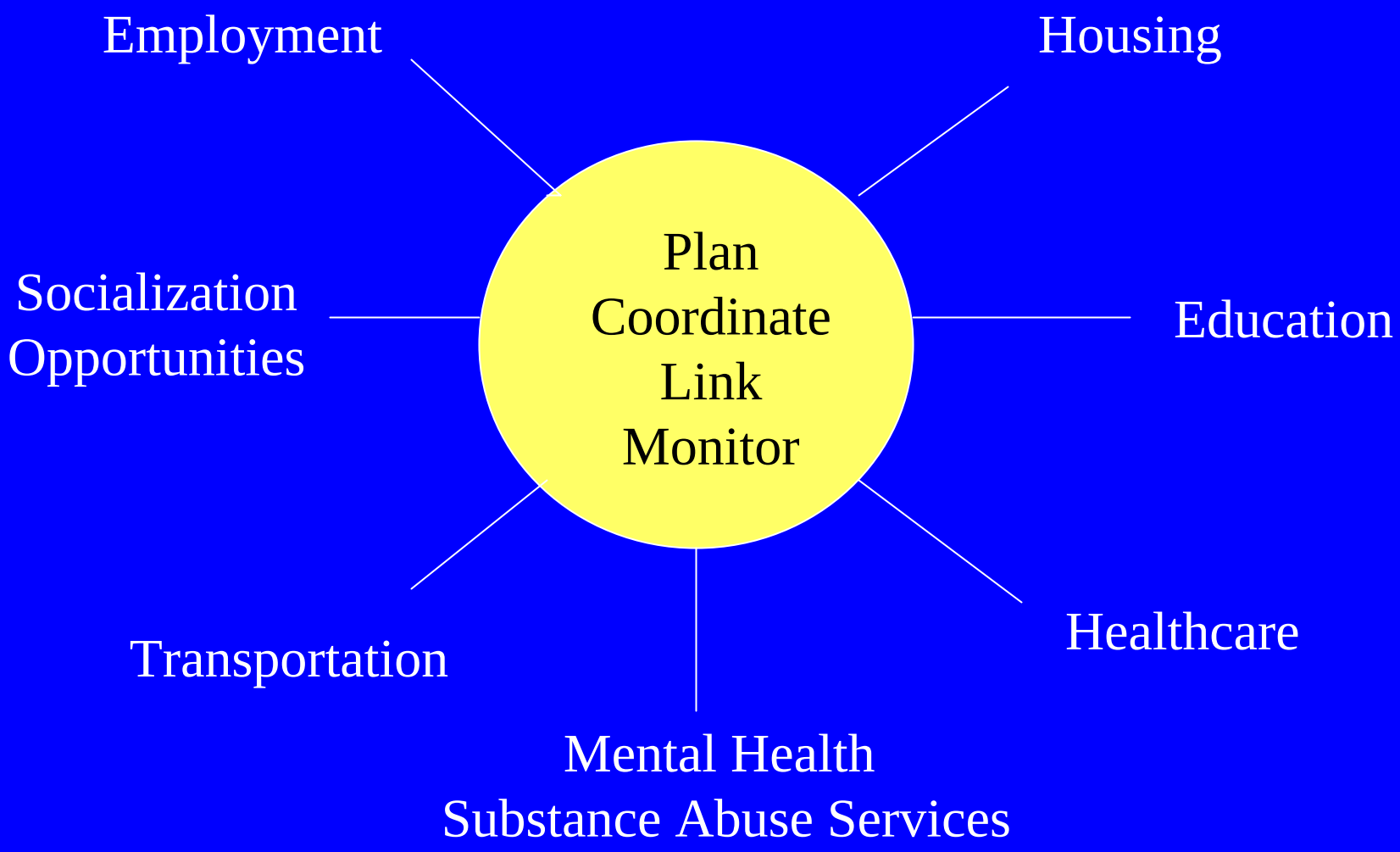
Estimates of Presence of Co-Occurring Mental Health Problems

- National studies of co-morbidity estimate 50 to 70% of those with long-term SA disorders have mental health problems
- Average estimates provided to OIG by:
  - Staff 70.6%
  - Supervisors 75.2%
  - Consumer self reports 41%

Integration of SA & MH Services

Degrees of Integration	Staff Estimate
SA & MH needs are met by the same team in a fully coordinated fashion	26%
Most SA & MH services are organized or even located separately but there is good coordination & access	47%
Most SA & MH services are organized separately and there is poor coordination & poor access	28%

Case Management Role



Finding #10

Average mental health case management caseload sizes are higher than national standards and higher than case mgr's, supervisors and consumers think is appropriate to ensure highest quality services

Caseload Size

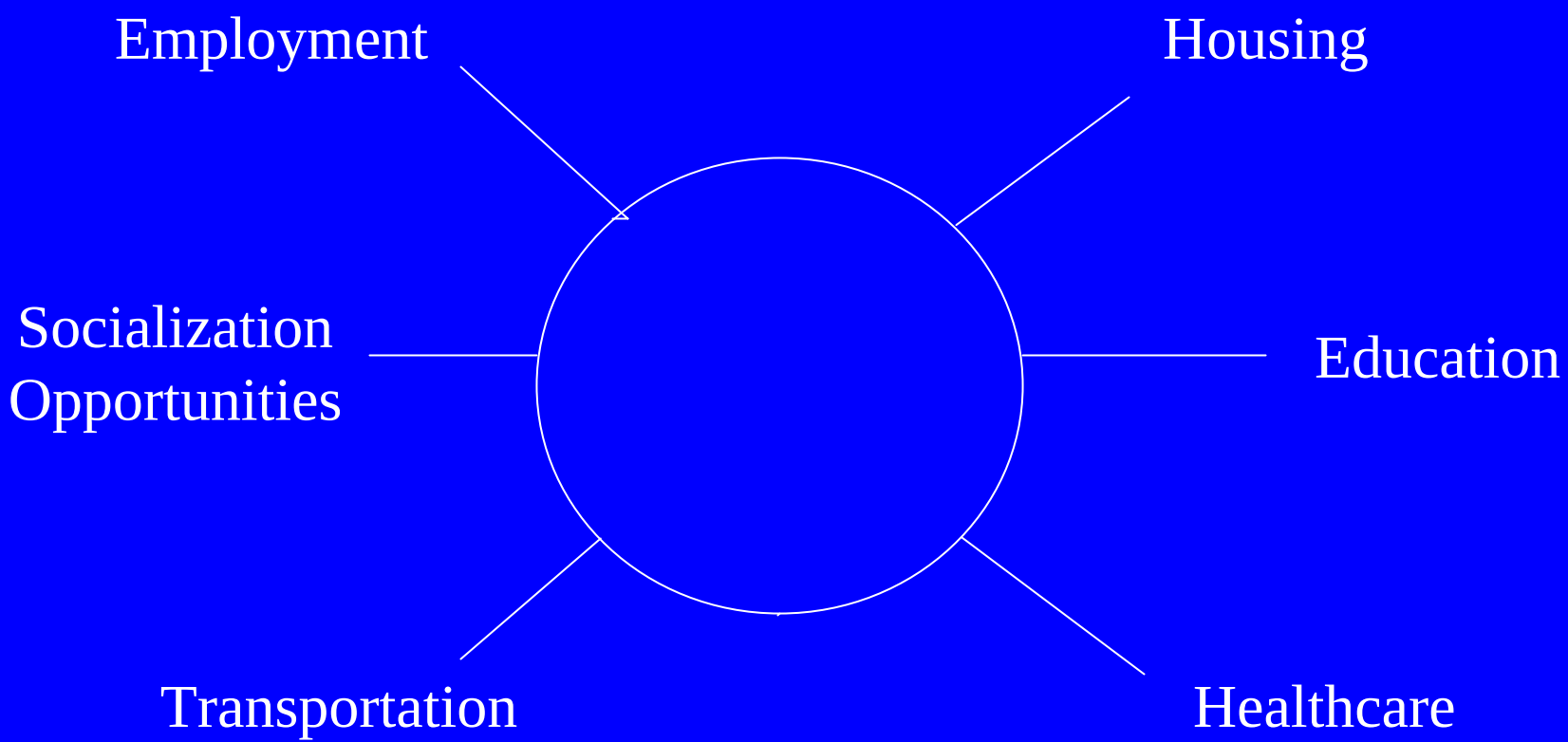
- Average caseload of fulltime CM is 40
- Caseloads reported by CSB:
  - Low CSB – 10
  - High CSB – 71
- 61% of case managers believe that their caseloads are too large
- Leading suggestion from CM, supervisors and consumers is that more CM are needed

Finding #11

Very few substance abuse outpatient consumers receive adequate case mg't

- 66% of case managers said CM capacity is inadequate
- 48% of SA consumers rated assistance by CSB with community needs poorly
- Only 27.5% of CSBs report adequate case management capacity
- Only 39% of records documented case management needs over past 90 days

Lack of Activities/Supports



Lack of Non-Emergency Services Increases Demand for Inpatient Services and TDO's

Complete OIG Reports with Findings, Recommendations, and DMHMRSAS Responses Available

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